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Chapter 18: Insurance

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CHAPTER 18

Insurance

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A. COURT DECISIONS

§18.1. Agents and brokers: Liability. During the 1958 SURVEY year the Supreme Judicial Court on two occasions considered the potential liability of an insurance agent or broker who fails to provide or is dilatory in providing insurance he has undertaken to effect for a client. In *Rapp v. Lester L. Burdick, Inc.*[1] the plaintiff brought an action in contract against an insurer and its agent for breach of an agreement to act promptly to cause the issuance of an accident and health insurance policy and in tort for negligent failure to do so. The plaintiff is administrator of the estate of one of more than six hundred members of the Advertising Club of Boston who were solicited by the agent to purchase insurance policies for which no physical examination was required and for which the agent accepted signed applications. Each application specifically provided that it was "subject to acceptance by the Commercial Casualty Insurance Company, Newark, N.J." The deceased made application on November 16, 1950, the agent forwarded it to the insurance company on December 14, 1950, and the policy was issued on January 2, 1951 following the death of the deceased on January 1, 1951. The Court found that no written or oral contract for insurance or temporary insurance was in effect at any time and consequently no claim existed under the policy. The Court refused to accept the view, which now finds support in perhaps a slight majority of the jurisdictions in which the question has been passed upon, that unreasonable delay in acting on an application for insurance gives rise to a right in tort or implied contract.[2] While there appears to be some support for the view that considerations of fairness and moral obligation should impose liability on an insurer in circumstances similar to those in the *Rapp* case, the needed correction, if any, should be accomplished legislatively, not judicially.[3]

Rayden Engineering Corp. v. Church [4] was an action against a firm

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§18.1. [1] 336 Mass. 438, 146 N.E.2d 368 (1957).

[2] See Annotation, 32 A.L.R.2d 487 (1953).

[3] Cf. Prosser, Delay in Acting on an Application for Insurance, 3 U. Chi. L. Rev. 39 (1935).

[4] 1958 Mass. Adv. Sh. 965, 151 N.E.2d 57; for further discussion of this case, see §3.3 *supra*.

of insurance brokers and its employee. The counts in contract alleged a failure to perform an undertaking to effect, for the plaintiff's benefit, a policy of insurance against accidental death of the plaintiff's employee and breach of an agreement that coverage would be bound immediately; the counts in tort alleged negligence in the performance of the undertaking to effect insurance and negligent failure to notify the plaintiff that the insurance had not been placed, with consequent loss to the plaintiff of the opportunity to place the insurance elsewhere. The defendant firm, through its employee, was acting as agent of the plaintiff in determining insurance needs of the plaintiff's newly established business and in placing policies. Among other policies, the plaintiff wanted at once a policy of accidental death coverage on a "key employee" who "was kind of a reckless driver." The defendant agent in response to the plaintiff's request for this coverage said, "I will take care of it, it is all set." About a month later the employee was killed in an automobile accident. In the meantime the defendant agent had taken no steps to obtain the accident policy.

The defendant agent had no authority to bind the accident coverage, and the Supreme Judicial Court found that the plaintiff could not reasonably assume that coverage was bound forthwith, particularly since the latter should reasonably have understood that a contract with its employee could not be made without the employee's assent. At most the undertaking was to use reasonable efforts to obtain and make effective thereafter an accident policy on the employee's life. But the agent purported to act for the firm with apparent authority and there was, therefore, no basis for a finding that the agent was undertaking a personal commitment that would sustain a contract action against him. The Court also affirmed a directed verdict for the defendant firm since the contract made was at variance with the contract declared on. The averment stated an undertaking to procure the policy, with the implication of a reasonable time within which to do so. Damages for breach of such an undertaking are computed on the basis of the provisions of the policy which should have been written. These agreements are, however, materially different from agreements to use reasonable efforts to procure policies of insurance.[5]

The defendant firm failed to perform obligations as an agent, for which the plaintiff could recover in tort. There was also evidence upon which the agent could have been found negligent as a sub-agent, who stands in fiduciary relationship to the principal and is subject to all of the liabilities of an agent to the principal except liability dependent upon the existence of a contractual relationship between them.[6] A majority of the Court sustained directed verdicts on the tort counts because the plaintiff failed to show that any negligence of the defendants resulted in substantial damage to the plaintiff, apparently doubting that a showing could be made that a policy could have been obtained, what it would have paid for the particular loss, and whether a claim would have been perfected. A motion to amend the declara-

[5] Heaphy v. Kimball, 293 Mass. 414, 200 N.E. 551 (1936).

[6] Cf. Seavey, Subagents and Subservants, 68 Harv. L. Rev. 658, 666-667 (1955).

tion to eliminate the variance was denied because failure to show substantial damage would require overruling of the contract counts except for nominal damages. Plaintiff should not have a second chance to show merely nominal damage.

§18.2. Accident insurance: Death or injury by accidental means. A prolific source of insurance law litigation for years has been those insuring agreements that obligate the insurer to pay or to indemnify for "injury caused by accident," for "accidental injury" or for "injury effected solely through accidental means." The "accidental means" language was involved in two companion cases decided by the opinion in *Brown v. United States Fidelity and Guaranty Co.*[1] The plaintiff unsuccessfully sought to recover double indemnity for accidental death under a policy of life insurance covering the life of her husband, and the death benefit afforded under an automobile accident policy taken out by her husband. Indemnity under each policy was payable only if insured's death "results as a consequence of bodily injury effected solely through external, violent, and accidental means" and excluded indemnity for death resulting "directly or indirectly from disease or from bodily or mental infirmity." The deceased, a coronary case for several years, suffered injuries in an automobile accident and died less than two months later. A clear distinction must be made between a death caused by a disease induced by the injury, where recovery can be had even though there is a predisposition or other frailty in the absence of which death might not have resulted, and the aggravation of a preexisting disease by an accident which together with the accident produces a fatal result, in which event the accident cannot be said to be the sole cause of death.[2]

§18.3. Life insurance: Incontestable clause. *Kramer v. John Hancock Mutual Life Insurance Co.*[1] was an action in contract brought by the beneficiary of a life insurance policy issued by the defendant insurer upon the life of the beneficiary's husband. The policy contained a typical "Policy when Void" clause making the policy "voidable by the Company" with respect of any claim for death occurring before the policy becomes incontestable if prior to the date of issue of the policy the insured had "any disease of the heart" and this fact is not endorsed on the policy. The insured died before the policy became incontestable and the insurer introduced medical testimony of a prior heart condition. As in the *Paratore* case,[2] involving an identical policy provision, the Court was of the opinion that compliance with the provisions of this "Policy when Void" clause is a condition precedent to the plaintiff's claim despite the express "voidable" language of the

§18.2. [1] 336 Mass. 609, 147 N.E.2d 160 (1958); the additional case decided by the same opinion was Brown v. Metropolitan Life Insurance Co.

[2] Leland v. Order of United Commercial Travelers of America, 233 Mass. 558, 564-565, 124 N.E. 517, 520 (1919).

§18.3. [1] 336 Mass. 465, 146 N.E.2d 357 (1957).

[2] Paratore v. John Hancock Mutual Life Insurance Co., 335 Mass. 632, 141 N.E.2d 511 (1957), discussed in 1957 Ann. Surv. Mass. Law §28.2.

policy. Testimony of physicians, who had examined the insured some years prior to the policy date, as to the fact of heart disease but not its exterior cause, including the electrocardiograms taken by one of them, was therefore improperly excluded by the trial court.

§18.4. Motor vehicle insurance: Ways of the Commonwealth. In *Farrell v. Branconmier*[1] the plaintiffs sought to reach and apply in satisfaction of judgments held by the plaintiffs against the defendant Branconmier the obligation of the defendant insurer under a compulsory motor vehicle liability policy. The Court found that an accident that occurred in a park area with no roads, paved or unpaved, that adjoined an ocean beach and was used generally for parking and entry to the beach and public buildings was not an accident that happened "upon the ways of the commonwealth," as required under the compulsory policy,[2] and defined as "any public highway, private way laid out under authority of statute, way dedicated to public use, or way under the control of park commissioners or body having like powers." [3]

§18.5. Motor vehicle insurance: Title to insured vehicle. *Middlesex Mutual Fire Insurance Co. v. Fireman's Fund Insurance Co.*[1] was a suit in equity to determine the liability of an insurer, which had issued to an automobile dealer a policy of theft insurance which by its terms covered "automobiles owned by the insured and held for sale . . . but excludes automobiles sold under a conditional sale, mortgage, lease, or similar agreement," and the liability of another insurer, which had issued to a customer of the automobile dealer a policy of insurance covering a 1946 automobile. The dealer had executed with its customer a purchase and sale agreement for a 1950 automobile, taking in trade the 1946 automobile, and assisted the customer in transferring the motor vehicle registration and the insurance afforded by customer's policy from the 1946 to the 1950 automobile, but retained physical possession of the 1950 automobile pending payment of the balance of the purchase price. Before payment, the automobile was stolen from the dealer's premises and subsequently recovered badly damaged. The Supreme Judicial Court held that the transfer of the registration, together with the other facts, justified the conclusion that the parties intended to transfer title upon execution of the purchase and sale agreement. Thus neither insurer had any liability to the automobile dealer, the first because its contract covered only automobiles owned by the dealer and held by it for sale, and the second because its contract covered only the interest of the dealer's customer.

§18.6. Policy conditions: Notice of accident. The plaintiff in *Segal v. The Aetna Casualty and Surety Co.*[1] was insured under a policy of liability insurance issued by the defendant insurer. One of the plaintiff's tenants using a common stairway was seized by an epileptic fit,

§18.4 [1] 1958 Mass. Adv. Sh. 633, 149 N.E.2d 363.
[2] G.L., c. 90, §34A.
[3] Id. §1.

§18.5. [1] 336 Mass. 315, 145 N.E.2d 723 (1957).

§18.6. [1] 1958 Mass. Adv. Sh. 435, 148 N.E.2d 659.

fell to the cellar and was taken to a hospital where he died two months later. The insured, apparently believing the accident was not within the policy coverage or that no claim would be brought, gave no notice of the accident to the insurer as required by the policy. Two months after the tenant's death and four months after the accident, the plaintiff received a notice of claim from an attorney for the deceased's estate which he promptly forwarded to the insurer. The Court held that even if this can be considered a notice of accident, despite the clear distinction in the policy between notice of accident and notice of claim, it was as a "matter of law" given too late to comply with the policy provision requiring a notice of accident within a reasonable time and the insurer was therefore not obligated to defend. A notice of accident is required to give the insurer an opportunity to investigate the cause and nature of a claim while the facts are still fresh in the minds of the parties and the insurer cannot be deprived of this contractual right.

In *O'Kane v. The Travelers Insurance Co.*[2] the plaintiffs had obtained judgments against the operator of an automobile not owned by him. The operator was, however, an insured under a policy of insurance issued to the owner of the automobile by the defendant insurer. The plaintiffs sought to reach and apply the property damage liability obligation of the policy. The operator gave the defendant no notice of the accident or claim, no copy of the summons, employed his own counsel, did not himself testify and in no way cooperated with the insurer. Consequently he has no rights against the insurer and his judgment creditors can have no greater rights. Neither can the plaintiffs reach the interests of the owner in the insurance for they are not his judgment creditors.

§18.7. Policy conditions: Proof of loss. The Supreme Judicial Court affirmed a directed verdict for the defendant in *Smith Beverages, Inc. v. Metropolitan Casualty Co.*[1] because of the plaintiff's failure to comply with policy requirements that proof of loss by alleged burglary be furnished to the insurer within sixty days from the date of discovery of the loss. Seasonable filing of the prescribed proof of loss was a condition precedent to the defendant's liability under the policy. Failure to file bars recovery unless the failure is excused or waived. No showing was made that the defendant refused to furnish a proof form or that there was any formal or written waiver of filing proof of loss "by endorsement . . . signed by a duly authorized representative of the company." Mere failure to provide proof forms does not constitute a waiver.

§18.8. Policy conditions: Assistance and cooperation. Two cases decided during the 1958 SURVEY year involved the "Assistance and Cooperation" clause in a motor vehicle liability policy. *Polito v. Galluzzo*[1] was an action to reach and apply the noncompulsory provisions

2 1958 Mass. Adv. Sh. 431, 148 N.E.2d 397.

§18.7. 1 1958 Mass. Adv. Sh. 531, 149 N.E.2d 146.

§18.8. 1 1958 Mass. Adv. Sh. 627, 149 N.E.2d 375.

of the defendant's motor vehicle liability policy in satisfaction of a judgment obtained by the plaintiff against the defendant as a consequence of injury sustained while riding as a guest in the defendant's motor vehicle on May 1, 1953. The original suit was brought on September 30, 1953 and the insurer entered an appearance for the defendant and agreed to assume the defense under a reservation of rights. The defendant signed and returned interrogatories sent to him on July 13, 1954. Notice sent to the defendant on October 5, 1955 advising of the approach of trial was returned undelivered. A constable sent to summon the defendant as a witness on the day before trial was unable to locate him, and he did not appear at the trial on November 2, 1955. The trial resulted in a verdict for the plaintiff. The plaintiff has no greater rights under the policy than the defendant insured. Disappearance of the insured and his failure to notify the insurer of his change of address were a material breach of the cooperation clause and warranted a disclaimer. An insurer knowing that it possesses sufficient grounds to disclaim cannot pursue the trial to a conclusion and then, an adverse result having been reached at the trial, disclaim liability. The insurer in the *Polito* case, however, defended under a reservation of rights and there was no way for it to notify the insured of his failure to cooperate. The insurer faced the serious question of whether to withdraw and leave the defendant unprotected or to try the case and put in a defense. Under these circumstances the Court affirmed the decree dismissing the bill as against the insurer.

McKissick v. The Travelers Insurance Co.[2] involved quite a different situation. In a previous action judgment was obtained against McKissick by a minor injured by McKissick's negligent operation of a motor vehicle owned by the minor's father and insured under a motor vehicle liability policy issued by the defendant in this action. The minor judgment creditor then brought a bill in equity to reach and apply the insurer's obligation under the policy; the bill was dismissed upon a finding that the minor's father and McKissick had deliberately given false testimony with intent to deceive in material matters, had highly prejudiced insurer in its defense efforts, and had violated the cooperation provision of the policy.[3] There is some suggestion that had the evidence been truthfully given in the original suit it probably would have sustained recovery. The present case is an action in contract by McKissick to recover the amount of the judgment obtained by the minor. The defendant seeks a declaratory judgment based upon an affidavit [4] of finding of the judge in the equity suit to which McKissick was not a party. The Court held that a bill in equity to reach and apply the proceeds of an insurance policy is a separate proceeding from an action in contract on the policy and is not res judicata as to it; it further stated that the findings of the judge in the equity suit as such would not be admissible if the contract action went to trial.

2 1958 Mass. Adv. Sh. 759, 150 N.E.2d 3.

3 Williams v. Travelers Insurance Co., 330 Mass. 476, 115 N.E.2d 378 (1953), discussed in 1954 Ann. Surv. Mass. Law §18.6.

4 G.L., c. 231, §59.

§18.9. Policy conditions: Subrogation. Two cases came before the Supreme Judicial Court during the 1958 SURVEY year as a consequence of the exercise by each of two insurers of the right of subrogation under policies of automobile collision insurance. In the first of these cases, *Bell Finance Co. v. Gefter,*[1] the Court held that an assignee of the conditional vendor of an automobile could maintain an action to recover the full amount of collision damage to the automobile caused by the defendant's negligence even though the conditional vendee was not in default on the note given under the conditional sale agreement. At the time of the accident the automobile was being driven by the conditional vendee, who was free from contributory negligence. The Court relied upon *Morris Plan Co. v. Hillcrest Farms Dairy, Inc.,*[2] which established the rule that the conditional vendor of an automobile could recover from a third person for negligently damaging the automobile while it was in the possession of a conditional vendee in default, notwithstanding the latter's contributory negligence. In the *Morris Plan* case the Court rejected the argument that a conditional sale is not a bailment as a ground for refusing recovery and asserted that a conditional vendor should have a right of action when a bailor would have one.

The *Bell Finance* case may be distinguished from the *Morris Plan* case, in which the conditional vendee was in default and the sum owed the plaintiff under the conditional sale agreement exceeded the amount of the damages, but, in the view of the Court, these distinctions were not so essential that the plaintiff should be denied recovery. Even though the conditional vendor or his assignee has no right of possession until default, he does have a security title to assure the payment of the debt and has a right to have his security unimpaired. It is upon this title to the property that the right of action against the third party is based and full recovery can be had, at least where, as here, there is no contributory negligence on the part of the conditional vendee. If the amount recovered exceeds the amount of the debt, the surplus must be held for the benefit of the conditional vendee.

Perhaps a logical extension of these cases is *Harvard Trust Co. v. Racheotes,*[3] which involved an automobile mortgaged to the plaintiff to secure a loan and damaged in a collision caused by the concurring negligence of the mortgagor and the defendant, the amount of the damage exceeding at the time of the accident the unpaid balance of the loan which was not in default. The mortgagor's insurer paid for the collision damage and the automobile had been restored to its condition prior to the accident. The Court agreed with the plaintiff that a chattel mortgagee should have similar rights to those of the conditional vendor but here faced the question of how much the mortgagee

§18.9. 1 1958 Mass. Adv. Sh. 305, 147 N.E.2d 815. This case is further commented on in §§3.2 and 7.2 *supra.*

2 323 Mass. 452, 82 N.E.2d 889 (1948).

3 1958 Mass. Adv. Sh. 309, 147 N.E.2d 817. This case is further commented on in §§3.2 and 7.2 *supra.*

should recover when the amount of the damage exceeds the unpaid balance of the loan and the mortgagor was contributorily negligent. To permit the mortgagee to recover for damage to the security more than the amount owed on the mortgage would permit the unjust enrichment of the mortgagor. Consequently, the Court limited the amount of recovery to the amount of the loan then unpaid.

These cases, each involving relatively trifling sums, represent efforts of automobile physical damage insurers to transfer property losses to liability insurers. The cases establish the rule that the potential right of repossession in the conditional vendor or chattel mortgagee is a sufficient interest to permit recovery for damage to the security even though the security may have been promptly restored by the insurer. As a practical matter, they may have the effect of giving an additional settlement value to difficult intersectional collision and other contributory negligence cases. The losses are all paid but additional expense is incurred, and sometimes, as here, new law is made as a redistribution of these losses among insurers is sought through subrogation actions. Legislative correction should, and very likely will, be sought for this situation. In cases such as these the conditional vendor or chattel mortgagee should be subject it would seem to the same defenses as would be available in a suit by the conditional vendee or chattel mortgagor.

B. Legislation

§18.10. Motor vehicle insurance. Since it became effective on January 1, 1927, the Compulsory Motor Vehicle Liability Insurance Law [1] has each year received considerable legislative attention. In recent years an alarming increase in the number and cost of automobile accidents and the consequent increase in the cost of automobile insurance has intensified interest in the operation and administration of the compulsory insurance system and focused attention upon the compulsory insurance rates set by the Commissioner of Insurance. These factors resulted in the creation in 1956 [2] of a special commission to investigate and study the motor vehicle laws and the insurance laws as they relate to motor vehicles. This special commission was revived and adequately financed in 1957 [3] and continued in 1958.[4]

Bills relating to the matters within the scope of the commission's investigation were referred in 1958 to the commission. Considerable time and effort has been devoted to a detailed study of the motor vehicle and insurance laws, and also to the problems of highway safety and traffic law enforcement, motor vehicle registration and driver licensing, the handling of damage suits and the curbing of exaggerated or fraudulent claims, all of which contribute to the mounting loss

§18.10. [1] G.L., c. 90, §§34A-34J.
[2] Resolves of 1956, c. 125.
[3] Acts of 1957, c. 402, §2.
[4] Resolves of 1958, cc. 27, 102.

costs that determine rate levels. Up to the close of the 1958 SURVEY year, no legislation has been enacted. The commission is expected to report its findings and recommendations to the General Court on or before the last Tuesday of December, 1958.

Of particular importance to the insurance companies was the repeal by Acts of 1958, c. 369 of the so-called Fielding Act [5] which required that all motor vehicle tort actions be commenced in a District Court. Effective September 1, 1958 these actions may be brought in either the District Court or in the Superior Court. This act further enables[6] the Superior Court on its own motion or on the motion of a plaintiff or defendant to transfer any action of tort or contract, including motor vehicle tort cases, to the District Court upon a determination that there is no reasonable likelihood that recovery will exceed one thousand dollars. These actions must be tried in the District Court by a full time justice. Any aggrieved party may as of right have the case retransferred to the Superior Court for determination by that court, with the decision of the District Court and the amount of damages assessed prima facie evidence as to the issues raised by the pleadings. These changes should do much to relieve the congestion of cases in the Superior Court.

§18.11. Accident and health insurance. In 1954 Massachusetts enacted the Uniform Individual Accident and Sickness Policy Provisions Law,[1] approved in 1950 by the National Association of Insurance Commissioners as a substitute on a national basis for the 1911 Standard Provisions Law for Accident and Health Insurance Policies. Legislative efforts at standardization of insurance policy provisions appear inevitably to fall short of the desired uniformity from state to state. The original Massachusetts enactment introduced two modifications;[2] two additional modifications were adopted during the 1958 SURVEY year. Acts of 1958, c. 277 [3] provides that no claim for loss incurred or disability commencing after two years (heretofore three years) from the issue date of the policy shall be reduced or denied because of a pre-existing disease or physical condition not specifically excluded from the coverage of the policy. Acts of 1958, c. 294 repeals the provision[4] by which an insurer may reserve the right of policy cancellation. Under the law as amended the insurer may refuse renewal of a policy but only upon thirty days' prior notice to the insured of intent not to renew.[5] Except for termination for non-payment of premium, any reserved right to refuse renewal may not be exercised except upon an

[5] G.L., c. 218, §19, as amended by Acts of 1954, c. 616, §1, discussed in 1954 Ann. Surv. Mass. Law §§4.7, 25.1, 27.6; G.L., c. 223, §2, as amended by Acts of 1955, c. 158, discussed in 1955 Ann. Surv. Mass. Law §§21.1, 23.10.

[6] G.L., c. 231, §102C, as added by Acts of 1958, c. 369, §3.

§18.11. [1] G.L., c. 175, §108, added by Acts of 1954, c. 275.

[2] See 1954 Ann. Surv. Mass. Law §§18.4, 18.5.

[3] Amending G.L., c. 175, §108, cl. 3(a)(2), 5th par.

[4] Id., cl. 3(b)(8).

[5] Id., cl. 3(a)(3).

anniversary of the policy or, in the event the policy has lapsed, upon an anniversary of its most recent reinstatement.[6] The changes with respect to cancellation and non-renewal appear to be an effort to achieve some balance between the need of the insured to maintain coverage into his advancing years and the needs of insurers seeking to make available low cost policies or experimenting with the development of newer forms of coverage.

Only one significant legislative development with respect to group accident and sickness insurance seems worthy of mention. For the tenth time in as many years a bill [7] to provide compulsory non-occupational disability benefits for Massachusetts workers was rejected by the House of Representatives and failed to reach the Senate. This type of legislation, enacted in four states,[8] during the early postwar years seemed destined for adoption generally. Since 1949, however, no state has adopted a compulsory system and there appears to be no non-political demand for this legislation.

§18.12. Life insurance. Acts of 1958, c. 114 amends the statute regulating the issuance of policies of life and endowment insurance[1] to permit the issuance of single life insurance policies on the lives of two or more members of a family upon an application signed by either parent, a step-parent, or by a husband or wife.

Acts of 1958, c. 188 amends the definition of group life insurance[2] to permit group life insurance to be written not only on borrowers and conditional purchasers, but also on guarantors or conditional guarantors of the debtors' obligations.

Acts of 1958, c. 410 enacts a new section[3] in the insurance law making a minor who has attained the age of eighteen years competent to give a valid discharge for payments not exceeding $2000 annually under an insurance policy, annuity contract or settlement agreement, provided the insurer has not had prior notice of the appointment of a guardian of the minor's property.

Acts of 1958, c. 117 enables savings and insurance banks to issue, under the Savings Bank Life Insurance Law,[4] policies of payor insurance but without otherwise increasing the aggregate amount of insurance that may be issued by one or more such banks on any one life.

§18.13. Group insurance: Public employees. Acts of 1958, c. 424 requires that a pro rata share of the dividends or other refunds or rate credits received by the Commonwealth on policies insuring the payment of benefits under the Group Insurance Plan for Employees of

[6] Added as id., cl. 3(b½).
[7] House No. 642.
[8] Rhode Island (1943), California (1946), New Jersey (1948), New York (1949).

§18.12. [1] G.L., c. 175, §123.
[2] Id. §133(c).
[3] Adding new §128A to G.L., c. 175.
[4] G.L., c. 178, §10.

the Commonwealth[1] shall be applied to the reimbursement of federal or other funds contributed in place of the Commonwealth's share of the premium cost as, e.g., in the case of employees whose salaries are paid in part from federal funds.

Acts of 1958, c. 355 enables the State Employees' Group Insurance Commission to empower the executive secretary of the commission[2] to appoint the employees necessary for the administration of the group insurance plan and to make payment of the required premiums.

Acts of 1958, c. 301 amends the state employees' group insurance plan[3] to make employees of a mosquito control project eligible for insurance.

Acts of 1958, c. 136 amends the Group Insurance Plan for Employees of Counties, Cities, Towns and Districts[4] to make certain employees of redevelopment authorities in cities and towns eligible for insurance.

§18.14. Insurance companies. Acts of 1958, c. 155 was enacted to permit the acquisition of one insurance company by another by an exchange of stock. The statute governing increases in capital stock [1] no longer requires that new stock must be offered to stockholders but it may, at the discretion of the directors, be disposed of for cash, property, services or expenses in whole or in part without being offered to the stockholders.

Acts of 1958, c. 296 [2] authorizes investment by domestic insurance companies in consolidated debentures of the federal intermediate credit banks and the banks for cooperatives organized under the laws of the United States.

Acts of 1958, c. 177 modifies the requirements with respect to the annual statement of life insurance companies[3] to require a schedule showing each bank in which an account was maintained together with the year-end balance and also the largest balance each month in any bank in which the largest balance carried during the year exceeded the smaller of one-fortieth of one percent of admitted assets of the insurance company or five hundred thousand dollars.

§18.13. [1] G.L., c. 32A, §9, added by Acts of 1955, c. 628, discussed in 1955 Ann. Surv. Mass. Law §17.3.
[2] G.L., c. 32A, §3.
[3] Id. §2(b).
[4] Id., c. 32B, §13, added by Acts of 1955, c. 760.

§18.14. [1] G.L., c. 175, §70.
[2] Adding new paragraphs 14D and 14E to G.L., c. 175, §63.
[3] G.L., c. 175, §25.